STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability - Identifying Liable Resources

Third party liability information relative to SSI applicants and recipients is forwarded to the Division of Medical Services by the Social Security Administration on an SSA 8019 form in accordance with the provision of the Section 1634 Agreement. This information is posted to the recipient eligibility file.

As Rhode Island is an automatic accretion state, the Social Security Administration accretes all eligible SSI recipients to the SMI Buy-In. This information is posted to the recipient eligibility file on a monthly basis.

Additionally, annual data exchanges are conducted with DEERS and Blue Cross/ Blue Shield of Rhode Island, a major health insurer covering over 80% of Rhode Island's population, for the purposes of identifying, accessing or recouping from the identified third party liability resource.

FOLLOW UP METHODOLOGY

The Department of Human Services utilizes the following methods of follow up for the purpose of identifying and accessing third party liabilities.

Information obtained from the Social Security Administration Wage and Earning File is forwarded to the appropriate eligibility supervisor in the district offices who assign a worker to verify the information. If earning information is already part of the case record, no further action is taken. If wages were previously unreported, the information is verified and referred to the recipient fraud unit if necessary. If the previously unreported employment provides for third party health insurance, it is reported to the Division of Medical Services on an AP23 form which specifies the type of coverage to include the health insurance membership number and the effective dates of coverage. Please see Attachment B. Upon receipt of the AP23 the information is posted to the recipient eligibility file on a daily basis.

Those Workers' Compensation cases involving Medical Assistance applicants and recipients are identified via the data exchange which is conducted monthly. This information is then forwarded to the applicant's or recipient's case worker who has the 175B form which contains specific third party liability information completed by the applicant or recipient. Please see Attachment C. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to insure recovery of the third party resource.

Those motor vehicle accidents involving Medical Assistance applicants and recipients are identified via the semi-annual data exchange with the Registry of Motor Vehicles. Any matches for which the agency has no information is referred

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to the applicant's or recipient's case worker who has the 175B form completed by the applicant or recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

All claims for payment for medical services other than hospital services with a trauma, poisoning or accident related diagnosis are screened by the appropriate specialist for the possibility of a third party liability. Those claims identified for which there is a possible third party resource are returned to the provider and are referred to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

Additionally, all hospital claims submitted with a trauma, accident or poisoning diagnosis requires the submittal of a TPL1 form. Please see Attachment D. This form gathers information relative to the circumstances surrounding the reason for seeking medical services and inquires as to whether the client is contemplating legal action and identifies the attorney if appropriate. The TPL1 form is reviewed by the appropriate specialist and is forwarded to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

ATTACHMENT A

AP-23
4/74

RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

PERSONAL RESOURCE FOR MEDICAL CARE

OFFICIAL

I. IDENTIFYING INFORMATION

CASE NAME _____ AFDC ☐ MA ☐ _____ (Case #) DATE _____

ADDRESS _____ S.S. #___ ___ ___/___ ___/___ ___ ___ ___

CITY/TOWN _____ TEL. NO. _____

II. MEDICAL INSURANCE PLANS

TYPE OF COVERAGE	Health Insurance Membership Number	Eff. Date of Coverage (If Known)	Resource No Longer Available (Eff.Date)
BLUE CROSS ☐ Individual ☐ Family ☐ Semi-Private ☐ $20.-A-Day ☐ *Co-pay ☐			
BLUE SHIELD ☐ Individual ☐ Family ☐ Plan A ☐ Plan B ☐ Plan U ☐			
MAJOR MEDICAL ☐ Individual ☐ Family ☐			
I. GROUP HEALTH ☐ Individual ☐ Family ☐			
GROUP PLAN UNDER PROV. HEALTH CENTER, INC. ☐ Individual ☐ Family ☐			
FEDERAL MEDICARE ☐ Part A ☐ Part B ☐			
OTHER - Specify			

*Co-pay: Semi-private coverage with insuree responsible for $15.00 per day.

III. MEDICAL NEEDS MET BY OTHER PERSON(S)

PERSON PROVIDING THE SERVICE	SERVICES PROVIDED		Resource No Longer Available (Eff.Date)
		HOSPITAL	
(Name) (Address)		PHYSICIAN	
(Name) (Address)		DRUGS	
(Name) (Address)		DENTIST	
(Name) (Address)		OTHER	
(Name) (Address)			

Yellow - Medical Standard & Review
White - Record
Blue - Recipient

Signature of Case Aide

F C LOCATION_____ **AUTHORIZATION FOR MEDICAL ASSISTANCE** ATTACHMENT B

Rev. [redacted]

Initial Certification ☐	DATE_____
Ger. (previously closed) ☐	
Ger. (previously denied) ☐	
☐	CASE NUMBER:
ification ☐	MA_____

A. PERSONAL INFORMATION

Name: Last First Middle Initial

Mail To: Number Street or Avenue

City/Town State Zip Code

Former Name of Address, if Changed:

4. Date of Birth | 5. Social Security Claim or Account Number ___-___-____

6. Date Eligibility Begins | 7. Date Eligibility Expires

8. Prior Category Numbers | 9. Cross Reference Number (s)

10. Sex: (Circle One) Male 2. Female | 11. (Office Use Only)

12. Marital Status (Circle One)
Never Married, 2. Widowed, 3. Married, living with spouse,
4. Divorced, 5. Separated 6. Not Applicable (child)

13. Eligibility Factor (Circle One)
65 & Over 2. Blind 3. Disabled 4. Death
5. Incapacity 6. Absence 7. Unemployed

14a. Number of Eligible Persons	
14b. Number of Eligible Children	

15. Health Insurance (Circle One in a to d below)
a. Social Security Part B. 1. Yes 2. No
b. Blue Cross 1. Yes 2. No. #_____
c. Physicians Service 1. Yes 2. No #_____
d. Other: 1. Yes 2. No If yes, complete:
Name of Company Policy Number
_____ _____

B. ASSETS

Does applicant own his own home? (Circle One) 1. Yes 2. No.

a. Real Estate	$_____
b. Cash	$_____
c. Stocks & Bonds	$_____
d. TOTAL	$_____
e. Insurance	$_____
f. Eligible Personal Property	$_____

C. ANNUAL INCOME

1. Net Earned Income $_____ 2. Social Security Benefits $_____
3. Other Government Benefits $_____ 4. All Other Income $_____
5. Total Income $_____

D. FLEXIBLE TEST (Circle One)

YES (Code 5) NO (Code 6)

If Yes, show use of $_____ excess income below:

OFFICIAL

E. FOR FAMILY CASES ONLY

NAME AND BIRTHDATE:

Spouse:_____
Children:_____

CHANGES	NAME	BIRTHDATE
Parent Added		
Parent Removed		
Child Added		
Child Removed		
Previous Unborn		

F. ☐ **ELIGIBLE** - The above - named are certified as eligible to receive Medical Assistance benefits.

G. ☐ **INELIGIBLE** - (Circle one)

1. Closing: Eff. Date_____
2. Rejection

REASON: (Circle One)

1. Does not have category characteristics.
2. Assets are in excess of maximum.
3. Income is in excess of maximum.
4. Eligible for money payment.
5. Death: Date_____
6. Form not returned
7. Other: (Specify)_____

SIGNATURE_____

EIN_____ TITLE_____

MASTER FILE	KEY PUNCH	VERIFY

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES AP-175b
DIVISION OF ECONOMIC AND SOCIAL SERVICES Rev. 3/87

ASSIGNMENT OF COLLATERIAL ASSISTANCE

Case Name _____ Case Number _____

Workers' Compensation Yes ☐ No ☐

OFFICIAL

KNOW ALL MEN BY THESE PRESENTS:

WHEREAS: I, _____ SSN _____

on behalf of _____ SSN _____
(injured party)

in consideration of medical care services and support to be furnished to me by the Department of Human Sevices under the provisions of 40-6-7, 40-6-8 and/or 40-8-4 of the General Laws of Rhode Island which assistance of medical care is necessary by reason of accident, injury, or illness sustained on _____ for which the following named third party may be liable:
(date)

Name _____

Address _____

and for which said accident, injury, or illness there are monies expected to be paid and provided to me by said _____, or on his/her behalf by:
(third party)

Insurance Company _____

Address _____

NOW THEREFORE, I, _____, do hereby assign as required by the above-named statutes or programs to the Department of Human Services an amount of money equal to the amount of medical care services and support furnished to me under the aforementioned categories of assistance as a reuslt of said accident, injury, or illness.

This assignment and agreement shall not operate as a lien against any amounts due me which are in excess of monies paid by the department for which medical care services and support were given.

I acknowledge that I have read this agreement or that it has been read to me, and I thoroughly understand its meaning before affixing my signature, that the statements herein made by me are true to the best of my knowledge and belief and are made under the penalties of perjury.

WITNESS MY SIGNATURE THIS _____ day of _____, 198____.

*Signature _____

Address _____

Notary or Witness Signature _____

If Attorney, Name _____

Address _____

Agency Representive _____

Office Location _____

***Requires original signature on all six (6) copies.**

ATTACHMENT D

ORIGINAL

Patient: _____ Where Treated:
Parent or Guardian: _____ Inpatient: _____
Address: _____ Outpatient: _____
Medical Assistance Number: _____ Date: _____

In view of the above treatment which appears to have resulted from a condition caused by an injury, the Rhode Island Medical Assistance Program requires submission of the information below before any payment can be made by the State of Rhode Island.

WAS HOSPITAL TREATMENT CAUSED BY AN ON-THE-JOB INJURY? Yes___ No___
If yes, where is patient employed? _____

1. If not injured on the job, where did the injury occur?
☐ Home ☐ Highway ☐ Other _____
Date: _____ Describe what happened: _____
_____
_____

Do you have any insurance to cover this injury? Yes____ No____

2. Was another party responsible for the injury? Yes____ No____
If yes, complete remainder of form.

a. Other Party — Other Party's Insurance Co.

Name _____ Name _____
Address _____ Address _____
_____ _____

b. Do you intend to make a claim against the other party or his insurance company for damages arising from the injury?
Yes_____ No_____

c. Have you retained an attorney for the enforcement of your rights? Yes_____ No_____

If yes, please list his name and address below:
Name _____ Address _____
_____

If you answered no to either b or c above and later file a claim, you are required to notify the Medical Assistance Program.

I agree to assign any rights I now have or may have to collateral benefits received as a result of accident, injury, or illness, equal to the amount of medical care or assistance furnished to me.

Signed: _____ Date: _____
Patient or Guardian